November 30, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0077-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
MAXIMUS Case #:

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in internal medicine and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he injured his back. The patient is status post a previous back injury in ___. An lumbar MRI performed on 10/6/98 indicated disc desiccation at L3-4 with small central, slightly right sided annular tear and contained annular protrusion with minimal effacement of the thecal sac, disc desiccation at L4-5 with small central annular tear and disc protrusion with minimal indentation on the thecal sac, disc desiccation and mild degeneration at L5-S1 without HNP. Treatment for this patient's condition has included epidural steroid injections, chiropractic treatment, therapy and medications. The current diagnoses for this patient include lumbosacral radiculitis, and lumbar disc disease. The patient has been recommended for a repeat lumbar MRI without contrast for further evaluation of his condition.

Requested Services

Repeat Lumbar MRI without contrast.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter from Injured Worker 10/20/04
2. Photographs
3. Required Medical Evaluation 9/21/04
4. Initial Consultation 9/22/04

Documents Submitted by Respondent:

1. MRI report 10/6/98
2. Required Medical Evaluation 9/21/04
3. History and Physical 7/30/04
4. Initial Office Consultation 6/3/97
5. MRI report 6/11/97
6. General Charge Tickets/Office Notes 7/7/97 – 10/2/97.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a male who sustained a work related injury to his back on ___. The MAXIMUS physician reviewer indicated that an MRI in 6/97 showed disc bulges and a protrusion at the L4-5 level. The MAXIMUS physician reviewer noted that the patient had been treated with medications, physical therapy, and epidural steroid injections and placed at maximum medical improvement with an 11% impairment rating in 4/98. The MAXIMUS physician reviewer also noted that the patient was reinjured in 9/98 and that a repeat MRI on 10/98 indicated degenerative disc disease and a protrusion at the L4-5 level. The MAXIMUS physician reviewer further noted that the patient was reinjured again in 6/04 and that an evaluation in 7/04 indicated positive straight leg raises and dermatomal sensory disturbances. The MAXIMUS physician reviewer indicated that an evaluation in 9/04 indicated no radicular changes and that a second evaluation in 9/04 further indicated positive straight leg raise. The MAXIMUS physician reviewer explained that a repeat MRI of the lumbar spine is indicated for a significant change in clinical findings such as a new neurological deficit or radicular findings. The MAXIMUS physician reviewer indicated that this is the case with this patient. Therefore, the MAXIMUS physician consultant concluded that the requested repeat lumbar MRI without contrast is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744

Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,
MAXIMUS

State Appeals Department

cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of November 2004.

Signature of IRO Employee

Name